We would like to thank everyone in our WV Region who came out to attend our provider seminars in May. The primary topics reviewed included the WV Medicaid changes which rolled in on July 1, 2015. We had a great turn out and a lot of good feedback. If you weren’t able to attend and would like to have a copy of the slide presentation, please visit our website at www.healthplan.org/providers/knowledge/training.

If you have any further questions about our seminars or need assistance with anything, please contact our Provider Relations Department at 1.800.624.6961.

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Medicare Part D Prescriber Enrollment

Any physician or other eligible professional who prescribes Part D drugs must either enroll in the Medicare program or opt out in order to prescribe drugs to their patients with Part D prescription drug benefit plans. Medicare Part D may no longer cover drugs that are prescribed by physicians or other eligible professionals who are neither validly enrolled, nor opted out of Medicare. All prescribers should enroll before January 1, 2016 to allow for the processing of applications and to ensure enrollees get their prescriptions. CMS has made available an enrollment file that identified physicians and eligible professionals who are enrolled in Medicare or opted out. An updated enrollment file will be generated every two weeks with a goal toward more frequent updates by the end of 2015. The enrollment file is available for download by visiting https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx.

Physicians and eligible professionals, including dentists, may complete the CMS-855O application to enroll in Medicare for the sole purpose of ordering, certifying, or prescribing coverable items or services (including Part D drugs) for their patients. The CMS-855O application is a short form and takes little time to complete. However, if the physician or eligible professional, including a dentist, intends to bill Medicare or Medicare beneficiaries directly (billing a Medicare Advantage plan does not constitute billing Medicare directly), they should complete the CMS-855I instead. Both the CMS-855O and CMS-855I may be completed electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at https://pecos.cms.hhs.gov/pecos/login.do. These applications are free of charge. Paper versions of the CMS-855I or CMS-855O applications are available at: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms-List.html.
Since the changes in HIPAA regulations went into effect on March 26, 2013, covered entities, business associates, and business associate subcontractors have had to re-evaluate their practices and/or documents, to stay compliant with the HIPAA-HITECH Omnibus Rule and incorporate these changes amid an ever-changing landscape encompassing technology, patient rights legislation, and day-to-day health care operations.

As part of the changes that occurred through these regulations, a business associate is now defined as a person who either creates, receives, transmits or maintains protected health information (PHI) or personally identifiable information (PII), through any connection with a HIPAA-regulated activity, or provides a service that would otherwise involve disclosure of PHI. Parties who provide services to business associates may now be considered “subcontractors” under the regulations, even though they may not have been directly subject to HIPAA previously. These covered entities are not required to have any agreements with a business associate’s subcontractors, but the Business Associate Agreement (BAA) between a covered entity and a business associate need to make it a requirement that the business associate ensures their subcontractor’s compliance through the BAAs with its subcontractors.

Covered entities may be held responsible for violations of HIPAA by their business associates if the covered entity holds authority to regulate the conduct of the business associate, other than contract termination. This means that if a business associate is considered an agent of a covered entity, then any required notification to affected individuals, the Secretary of Health and Human Services (HHS), and possibly the media must be made based upon the date the business associate or subcontractor first learns of the breach. This also applies to all business associate subcontractors. However, on a positive note, regulations clarify that a covered entity or business associate is generally not responsible for a breach by its business associates if they are not agents. Therefore, it is essential that covered entities and business associates know which of their business associates and/or subcontractors are their agents.

As part of the HITECH Act, covered entities are required to notify affected individuals in the event of a breach of unsecured PHI. This act defines a “breach” as an “unauthorized acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information,” with certain exceptions for unintentional disclosures. A breach depends upon whether there is a low probability that the PHI has been compromised based on the following four determining factors:

- Whether the PHI was actually acquired or viewed.
- The unauthorized person who used the PHI or to whom the disclosure was made.
• The nature and extent of the protected health information involved, to include what types of identifiers and any likelihood of re-identifying the individual(s) involved.

• The extent to which any risk to the PHI has been mitigated.

Covered entity or business associate bears the burden of proving that the PHI is not compromised in order to avoid determining that a breach has actually occurred.

Regulations have also raised the liability for HIPAA violations to range from $100-$50,000 per violation with an annual cap of $1.5 million. The scope of liability has also been expanded by subjecting business associates and all downstream entities/subcontractors to direct liability for certain HIPAA violations. HHS now treats an ongoing violation affecting multiple individuals as “multiple violations.” HHS will apply the number of violations derived from a breach based on the number of individuals whose information was disclosed. A fine could then be imposed of up to $50,000 for each disclosure, multiplied by the total number of affected individuals, to a cap of $1.5 million. If inadequate security of PHI continued over a period of time, and led to the same breach, a separate violation could result, permitting HHS to calculate the number of times the provision was violated based upon the number of days the violation continued. HHS could therefore impose a separate $50,000 fine for each violation of the Security Rule, multiplied by the number of days the violation occurred, subject to a separate $1.5 million cap for any calendar year. As exampled above, the individual or entity in this case could face up to $3 million in possible penalties.

Considering the potential scope of recent privacy legislation and impact of continuing incidents of computer hacking and theft of PII and PHI, all covered entities and related business associates should encrypt any PHI stored on desktops, laptops, mobile devices and removable storage devices, so in the event the device is misplaced or stolen, there will be a low, or mitigated risk of compromise, limiting potential of a breach occurring.

Further information on HIPAA and HITECH can be found on the Department of Health and Human Services Office for Civil Rights website at, http://www.hhs.gov/ocr/office/.

The Health Plan
Fraud Waste & Abuse Hotline
740.699.6111 or 1.877.296.7283

• The training must be completed within 90 days of the initial hire or the effective date of contracting and at least annually thereafter.

• You are required to maintain evidence of training for ten years; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.


REMINDER:
CMS Annual Training Requirements

CMS requires documentation from our providers of the completion of the compliance training in FWA on an annual basis. This will assist in meeting the regulatory requirement for training and education. The FWA training is a requirement of the Social Security Act, CMS, Office of Inspector General (OIG), and HIPAA privacy regulations, as well as state Medicaid programs.

• The training must be completed within 90 days of the initial hire or the effective date of contracting and at least annually thereafter.

• You are required to maintain evidence of training for ten years; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.

Contacting the Medical Director

Review Determinations

When review determinations are disputed or confusing for the attending physician, one available option is sometimes overlooked: A call to the medical director requesting clarification. It is a firm policy of The Health Plan that a medical director will always be available during business hours to discuss such rulings and the reasons behind them. Ordinarily, the conversation needs to take place between two physicians rather than be transmitted through third parties in either office. Frequently, a determination will change because of new information imparted during a conversation between the two physicians, but this is usually not possible when intermediaries, no matter how capable, are involved.

Of course, the standard appeal mechanisms will always be available, but sometimes a prompt resolution can be achieved in this manner without going through more elaborate procedures.

"...a Medical Director will always be available during business hours..."

When physicians make such an inquiry, having the patient’s complete name, referral number and ID number available will enable the medical director to access the electronic record at the outset of the call and in most cases resolve the issue or completely answer questions during the initial conversation. It is not mandatory to have this information in order to initiate a discussion, but without a number to identify the ruling in question the medical director may have to call back after the patient’s record has been identified in the computer files.

Claims and eligibility issues are usually more quickly handled by the Claims Department or the Customer Service Department, but we will help whenever we can.

You may reach the medical director at The Health Plan by calling 740.695.7643 or 7644 or by calling 1.800.624.6961, ext. 7643 or 7644.

The Health Plan Affirmative Statement

Regarding Incentives August 2015

The Health Plan bases its decision making for coverage of health care services on medical appropriateness utilizing nationally recognized criteria. Incentives are not offered to providers or The Health Plan employees involved in the review process for issuing non-authorization, nor does The Health Plan specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage.

Also, no incentives are given that foster inappropriate under-utilization by the provider, nor does The Health Plan condone under-utilization, or inappropriate restrictions of health care services.
Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, their circumstances, medical history and availability of care and services within The Health Plan network. Input is sought annually or as needed in the review of criteria from physicians participating in the Physician Advisory Committee.

The Health Plan utilizes McKesson InterQual® Criteria as a screening guideline to assist the nurse reviewers with respect to medical appropriateness of health care services, including behavioral health. Any participating provider may, upon request, review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

InterQual® may be utilized to assist in the review of admissions, surgical and radiological procedures including, but not limited to, MRI, MRA, CT Scan, hysterectomy, ECT, and psychological testing.

You may call The Health Plan Medical Department 1.740.695.7643 or 1.800.624.6961, ext. 7643 or 7644, or Behavioral Health Services at ext. 7896, if you have a general InterQual® question or a question regarding a particular case. InterQual® review worksheets are available upon request.

Please indicate if your request is emergent so that we may expedite the review.

Simply scheduling the testing/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by The Health Plan.

Flu clinic dates, times and locations

**The Health Plan 2015 Flu Clinics**

**Saturday September 19, 2015**
9 a.m. – 1 p.m.
Massillon Rec Center
505 Erie Street North
Massillon, OH 44646

**Saturday October 3, 2015**
9 a.m. – 1 p.m.
Bridgeport High School
55707 Industrial Drive
Bridgeport, OH 43912

The flu shot requires no prescription, and no appointment is needed! Our members can get the flu vaccine at any pharmacy that has it available this year and that accepts The Health Plan insurance.

All family members who currently have The Health Plan coverage and are at least 19 years of age are invited! Anyone under the age of 19 must get the flu vaccine at a doctor’s office and can’t go to a pharmacy or a flu clinic of The Health Plan to receive it.
Improving Patient Wait Times
A little courtesy goes a long way

While The Health Plan’s access to care guidelines suggests a wait time of 45 minutes, most patients begin to feel frustrated and anxious after waiting only 20 minutes. In today’s busy practices, extended wait times are often unavoidable.

There are several things providers can do to help minimize how long patients feel their wait time is:

• Encourage patients to arrive and sign in 10 minutes prior to their appointment.

• Advise patients if the provider is running behind.

• Let them know the reason for the delay, and how long it will be until the provider sees them.

• Offer to reschedule appointments if the wait time is longer than 45 minutes.

• Provide current magazines and newspapers in waiting rooms to offer distraction.

• Add a water cooler or beverage station.

• Add a guest wi-fi connection so patients in the waiting room can use their portable devices.

• Play soft music in the waiting room.

Self-assessment of wait times in your office cannot only help to identify problems and bottlenecks, but is also a simple way to increase patient goodwill by showing them that you value their time. Give patients a clipboard and pen as they arrive. Ask them to write down:

A. The time they arrive in the office.

B. The time they are shown to an exam room.

C. The time the doctor or provider arrives in the exam room.

D. The time the doctor leaves the exam room.

E. The time they leave the office.

By reviewing the results, offices can determine if the patient flow process needs to be changed to move patients more efficiently.

Keeping Information Up-to-Date
It is very important to be current

In this electronic age of direct deposit, electronic remittance advices, and electronic submission of claims, you may lose sight of remembering to notify The Health Plan of any changes. It is important to notify us of any changes, such as a change in your physical location, telephone number, back up coverage, hospital affiliation and practice restrictions. All of this information is gathered in order to provide the most current information to our members in the form of directories, whether they are electronic or paper.

To ensure you are correctly listed in our directories, please take a minute to check the information on our website, healthplan.org. Go to “Find a Provider,” Option 1 search button, in step 1 enter your last name only, step 2 select “All Providers” and then go to the submit button. Double click on the appropriate underlined full name of the doctor. Your provider detail information will be displayed for review.

It is very important to remember to contact The Health Plan with any changes to your office location, telephone numbers, back up physicians and hospital affiliations.

The Health Plan • 52160 National Road East • St. Clairsville, OH 43950-9306 • 1.800.624.6961 • healthplan.org
Coordination of Care

The goal of continuity and coordination of care is the seamless transition of patient care from one setting to another. It includes all aspects of a member’s care and all of the providers involved in that care. The PCP is the most appropriate connector. A member’s communication with their PCP will enhance their overall health and enable their PCP to direct their care so that all appropriate medical providers are involved. We encourage our members to keep their PCP informed of any change in their medical condition including visits to an intermediate, skilled, or rehab facility; an inpatient or outpatient center; an emergency room or urgent care setting; a VA clinic, health fair, mental health care provider, or specialist; as well as any tests, medications, or treatments that were recommended.

We also strongly encourage the specialist providers to mail or fax medical updates to the PCP for inclusion in the member’s chart. If your office has not received these reports, we encourage you and your staff to contact these entities and to include the information in the patient’s medical record.

For improved continuity and coordination of care, we suggest the following:

- Phone consultation or conference calls when multiple doctors are involved in the member’s care.
- Concise documentation in the medical record to show that PCP/specialist consultation has occurred.
- Mail or fax medical updates to the PCP and other specialists involved in the patient’s care.

For improved continuity and coordination of care for our behavioral health members, our behavioral health providers are encouraged to discuss with their patients the importance of sharing their behavioral health care issues with their PCP. A release form is available by calling Behavioral Health Services at 1.800.624.6961, ext. 7301.

Welcome

The Health Plan has hired Roxanne Loughery as behavioral health liaison. Her primary responsibilities will be coordination, negotiation and management of behavioral health service agreements with an emphasis on West Virginia Comprehensive Care Centers. Roxanne previously worked over 14 years with The Health Plan as a provider relations representative. Her office is located at 48 Donley Street, Suite 502, Morgantown, WV 26505 and she may be reached at 1.800.598.3911, direct at 304.285.6505 or rloughery@healthplan.org.

REMINDER

Signatures, Credentials and Dates Are Important

Each entry in the patient’s medical record requires the acceptable signature, including credentials and the date of the person writing the note.

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Procedural Manual, Section 3. If you would like a copy please contact the provider relations customer service representatives at 740.695.7901 or call 1.800.624.6961, ext. 7901.
The Health Plan has announced that five employees recently passed the Freedom From Smoking certification from the American Lung Association.

The Freedom From Smoking program has been helping smokers quit for over two decades. The eight module program is offered as a group clinic in many areas of the country. Participants in Freedom From Smoking develop a personalized step-by-step plan to quit smoking.

Each session uses a positive behavior change approach and encourages participants to work through the problems and process of quitting individually, as well as in a group.

Evidence has shown that Freedom From Smoking is very effective at helping smokers quit.

You know smoking is bad for your patients. They have probably thought about quitting or they may have even tried to quit. If they are still smoking, they may need help to quit.

It is not easy, but it can be done, with the right support and tools. Many people have kicked the habit.

It is never too late to stop smoking: by quitting your patients can live a longer, healthier life.

For more information on this program, please call The Health Plan at 740.695.3585 or 1.800.624.6961, ext. 7659.

If your patients have any questions concerning their benefits for smoking cessation agents, or any questions in general about the agents they can call The Health Plan at 740.695.3586 or 1.800.624.6961, ext. 7914.